PROGRAM DESCRIPTION CHECKLIST (FCR 2FFA)

SUBMIT ONE FOR EACH PROGRAM FOR WHICH A RATE IS REQUESTED

Agency Fiscal Year	Number of Months
____ ____ - ____ ____ MO YR MO YR	

PART A. PROGRAM IDENTIFICATION

1. AGENCY NAME	
2. PROGRAM NAME	Program Number ____ • ____ • ____

PART B. PROGRAM DESCRIPTION

1. TYPE OF PROGRAM (CHECK ONE)

☐ TREATMENT ☐ NONTREATMENT

If Program is Nontreatment, Complete Section B, 3, 4 and 5 only. Do Not Complete Part C

Average number of Certified Homes in Reporting Period _____

2. POPULATION TYPE(S) OF THIS PROGRAM IS:

NOTE: (ENTER "1" FOR DESIGNED TO TREAT: "2" FOR MAY ACCEPT: "3" FOR WILL NOT ACCEPT)

CLIENT CHARACTERISTICS

☐	01 MENTAL RETARDATION - MILD (EMR)	☐	15 HYPERACTIVITY	☐	27 SCHOOL PROBLEMS
☐	02 MENTAL RETARDATION - MODERATE (TMR)	☐	16 AUTISM	☐	28 ALCOHOL ABUSE
☐	03 MENTAL RETARDATION - SEVERE	☐	17 ACTIVELY PSYCHOTIC	☐	29 DRUG ABUSE
☐	04 PHYSICAL HANDICAPS BUT AMBULATORY	☐	18 SEVERE DEPRESSION	☐	30 CHRONIC RUNAWAY
☐	05 NON-AMBULATORY	☐	19 SELF-DESTRUCTIVE	☐	31 CHRONIC PLACEMENT FAILURE
☐	06 LEARNING DISABILITY	☐	20 ACTIVELY SUICIDAL	☐	32. OTHER (SPECIFY) _____
☐	07 DEAFNESS	☐	21 OTHER EMOTIONAL		_____
☐	08 BLINDNESS		DISTURBANCE *(SPECIFY)*		
☐	09 NON-VERBAL COMMUNICATION		_____		
☐	10 EPILEPSY	☐	22 SEXUAL ACTING OUT		
☐	11 CEREBRAL PALSY	☐	23 BEHAVIOR/CONDUCT DISORDER		
☐	12 DIABETES	☐	24 FIRESETTING		
☐	13 SEXUAL OR PHYSICAL ABUSE	☐	25 ASSAULTIVE		
☐	14 PREGNANCY	☐	26 POSSIBLE VIOLENCE		

3. TYPE OF PROGRAM EMPHASIS *(CHECK ONE)*

☐ EMERGENCY SHELTER CARE ☐ SHORT-TERM DIAGNOSTIC ☐ EMANCIPATION ☐ REUNIFICATION ☐ OTHER_____

4. ANTICIPATED DURATION OF CARE *(CHECK ONE)*

☐ 30 DAYS OR LESS ☐ 31-90 DAYS ☐ 91-180 DAYS ☐ 181 DAYS OR MORE

(Instructions on Page 3)

PROGRAM NAME	PROGRAM NUMBER

5. SOURCE OF PLACEMENT

a. NUMBER OF CHILDREN PLACED *(BY PLACEMENT AGENCY)*

01 COUNTY WELFARE Department

03 REGIONAL CENTER

05 OTHER *(Specify)*

02 COUNTY PROBATION

04 PRIVATE *PLACEMENT*

06 OTHER *(Specify)*

b. LIST AGENCIES USING PROGRAM. LIST PRIMARY USER FIRST AND OTHERS IN DESCENDING ORDER OF USAGE.

PART C. PROGRAM CHARACTERISTICS *(Treatment Programs only complete this section)*

1. **PSYCHIATRIC SERVICES OFFERED:**

a. DIRECT PSYCHIATRIC SERVICES TO CHILDREN ☐ ALL ☐ SOME ☐ LITTLE OR NONE

b. ONGOING PSYCHIATRIC CONSULTATION ON PROGRAM DESIGN AND STAFF TRAINING: ☐ YES ☐ NO

2. PSYCHOLOGICAL SERVICES OFFERED:

a. DIRECT PSYCHOLOGICAL SERVICES TO CHILDREN ☐ ALL ☐ SOME ☐ LITTLE OR NONE

b. ONGOING PSYCHOLOGICAL CONSULTATION ON PROGRAM DESIGN AND STAFF TRAINING ☐ YES ☐ NO

3. SOCIAL WORK ACTIVITIES:

a. WHAT ARE THE MINIMUM QUALIFICATIONS REQUIRED OF PERSONS PERFORMING SOCIAL WORK ACTIVITIES?

b. ENTER THE NUMBER OF HOURS SPENT ANNUALLY BY PERSONS, ON PAYROLL OR CONTRACT, PERFORMING SOCIAL WORK ACTIVITIES:_____

C. ATTACH TO THE RATE APPLICATION DOCUMENTATION OF THE QUALIFICATIONS FOR PERSONS CURRENTLY PERFORMING SOCIAL WORK ACTIVITIES OR LICENSE.

FCR 2FFA, PROGRAM DESCRIPTION CHECKLIST

PURPOSE:

The Program Description Checklist captures specific information about each program for which an FFA rate is being requested. This information will be entered into a computerized information system and will be used to classify FFA programs into categories relative to services offered.

INSTRUCTIONS FOR COMPLETION:

Submit one FCR 2FFA for each program for which a rate is being requested.

Agency Fiscal Year: Enter the beginning and ending month and year for the agency's fiscal year (e.g., 01/90 - 12/90).
Number of Months: Enter the total number of months, (e.g., 12 months) for which costs are reported.

PART A, PROGRAM IDENTIFICATION:

Line 1: Enter the name of the Agency (same as on FCR 1FFA, Line 2).

Line 2: Enter the name from the FCR 1FFA, Line 9.
Enter the program number, if known.

PART B, PROGRAM DESCRIPTION:

Line 1: Check the type of program. Check only one box.
If Program is Nontreatment, Complete Part B. 3, 4 and 5 only. Do not Complete Part C. Enter the average number of certified homes during the reporting period.

Line 2: Check all items which describe the client characteristics which this program is designed to treat. Use the box to mark either 1, 2, or 3 for each item. Use "1" to designate problems that this program is designed to treat.Use "2" to designate problems that this program may accept, but are not the primary focus of the treatment program. Use "3" to designate problems that would prevent a child from being accepted in this program.

Line 3: Check the type of program emphasized by the FFA. Check only one box.

Line 4: Check the anticipated duration of care. Check only one box.

Line 5a. Enter the number of children placed during the cost period by type of placement agency. Disregard funding source (e.g., a child funded by AFDC-FC through the Welfare Department but placed by Probation, would be marked under Probation; a child whose placement is reimbursed by Champus, but was placed by his/her parents, would be a private placement).

Line 5b. Identify the county agencies placing children with the FFA. Identify by county welfare, county probation departments or other placing agency, in descending order of usage.

PART C, PROGRAM CHARACTERISTICS:

Enter the program name and number as shown on the first page of the FCR 2FFA.

Lines 1-2. **Check** the answer which most closely describes your FFA program. A single answer may not **exactly** fit your FFA program; however, select the answer that is predominant for your program.

Line 3a. Describe the minimum qualifications required of persons performing social work activities.

Line 3b. Enter the total number o f hours of all hours spent annually by all persons performing social work activities.

Line 3c. Attach to this state application the documentation which shown the qualifications of persons currently performing social work activities. This documentation may include college diploma or transcripts or copy of licensed Clinical Social Worker or Marriage, Family and Child Counseling licenses.